STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN PARK ASSISTED LIVING COMMUNITY	5045 W 52ND ST INDIANAPOLIS, IN 46254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for Investigation of Complaint IN00108144. Complaint: IN00108144- Substantiated: State Deficiency related to the allegation is cited at R0091. Survey date: May 8, 2012 Facility Number: 003915 Provider Number: 003915 AIM Number: N/A Survey Team: Patti Allen, BSW- TC Dinah Jones, RN Marcy Smith, RN Census Bed Type: : Residential: 53 Total: 53 Census Payor Type: Other: 53 Total: 53 Sample: 3 This state finding is cited in accordance with 410 IAC 16.2. Quality review completed on May 14,	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	2012 by Bev Faulkner, R.N.			

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R0091	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on record review and interview, the facility failed to ensure they had a policy in place regarding reporting immediately to the Administrator when a narcotics count could not be reconciled. This involved the theft of narcotic medication belonging to Resident #A. Findings include: Review of an Incident Report Form, dated 4/29/12, written by the Administrator of the facility and faxed to the Indiana State Department of Health on 4/29/12 at 8:01 p.m., indicated the "narcotic count was off on "Friday night on April 27, 2012." "A card of #30 Hydrocodone was missing." This missing card of #30 Hydrocodone belonged to Resident #A. Included with the Administrator's report	R0091	Facility has replaced the narcotics for Resident A.All Narcotics were reconciled for all residents on 4/29/2012 by the DON, ADON and Administrator, all counts were accurate with the exception of Resident A's Hydrocodone.On 5/1/2012 a new written policy was implemented for the receipt, administration, and reconcilation of all controlled medications/narcotics. All nursing staff have been inserviced on the policy and reporting procedures as of 5/23/2012.Administrator or Designee will verify that Narcotic Count Sheets are executed with the proper signatures. Administrator or Designee will monitor randomly each week and document, date and time of review.	05/23/2012

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	was a hand written account by the Wellness Director, which indicated the staff had tried to contact the Assistant Director of Nursing (ADON) on Friday night but were unable to reach her. The report indicated the staff waited until Saturday morning to contact the Wellness Director to notify her of the unreconciled narcotic count. The Wellness Director, in this report, indicated she began an investigation of the unreconciled Hydrocodone count on Saturday morning, 4/28/12. A Qualified Medication Assistant (QMA) eventually admitted on 4/28/12 to the theft of the Hydrocodone, according to the report, and returned the medication to the facility. In the report, the Wellness Director indicated "11:45 a.m. (Sunday ...) Called [sic] placed to [name of Administrator] to let her know what was happening ...then [name of administrator] placed a call to the police department." On the Incident Report Form sent to The Indiana State Department of Health, the Administrator indicated "On Sunday April 29, 2012, it was reported to this writer by the Wellness Director ...that			

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	during a narcotic count on 4/28/12 it appeared that 30 Hydrocodone were not present in the narcotic box.... " During an interview with the Administrator on 5/8/12 at 1:30 p.m., she indicated the date of 4/28/12 was incorrect, she meant 4/27/12. In this interview she indicated the QMA had been terminated as of 4/27/12. On 5/8/12 at 1:30 p.m., a facility policy regarding immediate notification of the Administrator if a narcotic count could not be reconciled was requested. On 5/8/12 at 2:40 p.m. the Administrator indicated the facility did not have a policy in place at the time of the 4/27/12 occurrence regarding the immediate notification of the Administrator for an unreconciled narcotics count. At this time she provided a policy addressing this issue, dated 5/1/12. During an interview with Resident #A on 5/8/12 at 2:30 p.m., she indicated she couldn't remember any time when she was not able to receive her pain medication if she needed it.			